

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10855

CERTIFICATE OF DEATH

10858

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>OAKLAND</u>				TOWN <u>RURAL</u> <u>SWANTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE #1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) (BABY GIRL) <u>BERNARD</u>				<u>NOVEMBER 17</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>F</u>	<u>W</u>	<u>SINGLE</u>	<u>NOVEMBER 17, 1955</u>			<u>6</u>	<u>53</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OAKLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>LEROY WADE BERNARD</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN SCHMIDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ROUTE #1</u> <u>MR. LEROY WADE BERNARD SWANTON, MARYLAND</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 hrs 53 min</u>	
176x IMMEDIATE CAUSE (A) <u>Prematurity (6 mos.)</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-17</u> , 19 <u>55</u> , to <u>11-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-17</u> , 19 <u>55</u> , and that death occurred at <u>9:05</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>James H. Seaton Jr.</u>				ADDRESS (Street, city, town, state) <u>Oakland Md.</u>		DATE SIGNED <u>11-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/17/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
24. REC'D BY REGISTRAR <u>11/17/55</u>		REGISTRAR'S SIGNATURE <u>Julius A. Power L.R.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	

CERTIFICATE OF DEATH

10528
111

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. SMITH		45		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
1234 E. MAIN ST.		Carpenter		High School		Married		Pneumonia		Pneumonia	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
NOV 28 1922		HOME		10:30 AM		101.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER		SIGNATURE OF OTHER	
J. M. SMITH		J. M. SMITH		J. M. SMITH		J. M. SMITH		J. M. SMITH		J. M. SMITH	

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other person having knowledge of the cause of death. It is to be filled out in duplicate, one copy to be retained by the physician and the other to be sent to the State Department of Health, Baltimore, Md.

2. The name of the deceased should be written in full, including the middle name if there is one.

3. The age should be given in years and months.

4. The sex should be given as male or female.

5. The race should be given as white, negro, or other.

6. The date of birth should be given in full, including the day, month, and year.

7. The place of birth should be given in full, including the city, county, and state.

8. The residence should be given in full, including the street, city, county, and state.

9. The occupation should be given in full, including the name of the occupation.

10. The education should be given in full, including the name of the school and the degree.

11. The marriage should be given in full, including the name of the spouse and the date of marriage.

12. The previous illness should be given in full, including the name of the illness and the date of onset.

13. The cause of death should be given in full, including the name of the disease and the organ affected.

14. The date of death should be given in full, including the day, month, and year.

15. The place of death should be given in full, including the city, county, and state.

16. The time of death should be given in full, including the hour, minute, and second.

17. The temperature should be given in full, including the degree and the unit.

18. The pulse should be given in full, including the rate and the character.

19. The respiration should be given in full, including the rate and the character.

20. The signature of the physician should be given in full, including the name and the title.

21. The signature of the witnesses should be given in full, including the name and the address.

22. The signature of the deceased should be given in full, including the name and the address.

23. The signature of the funeral home should be given in full, including the name and the address.

24. The signature of the minister should be given in full, including the name and the address.

25. The signature of other should be given in full, including the name and the address.

BUREAU V. S.

NOV 28 1922

RECEIVED

Burial

11/27/22

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10856

CERTIFICATE OF DEATH

10859

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Lonaconing</u>		<u>Life</u>		TOWN <u>Rural Lonaconing</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WADE</u> <u>H.</u> <u>BROADWATER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>New Germany, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David D Broadwater</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Colmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>R.D. Mrs. Effie Broadwater, Lonaconing</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>myocarditis</u>						<u>34 15 -</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Duodenal ulcer</u>						<u>6 mo</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 19 48</u> to <u>Nov 25 55</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>55</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>P. E. Berry</u>				ADDRESS (Street, city, town, state) <u>M.D. Piedmont</u>		DATE SIGNED <u>11/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Germany Methodist</u>		LOCATION (City, town, or county) (State) <u>New Germany, Garrett Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11/26/55</u>		REGISTRAR'S SIGNATURE <u>Ethel Broadwater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10860

10857 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Alle gany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oakland</u>		<u>9 months</u>		TOWN <u>Cumberland</u>		<u>01-02-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Weeks Nursing Home</u>				STREET ADDRESS (If rural give location) <u>17 Valley St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Daisy M. Coleman</u>				<u>Nov. 10, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>May 6, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if housewife)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Cumberland, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Coleman</u>				<u>Sarah Bucy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Quenten Griffey, Ellerslie, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>3-4 mos</u>	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cardiac Asthma</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Art. C. V. D.</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3, 1955</u>, to <u>10 Nov, 1955</u>, that I last saw the deceased alive on <u>11 Nov, 1955</u>, and that death occurred at <u>11:50 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Lushy</u> M.D.				ADDRESS (Street, city, town, state) <u>Cahland, Md</u>		DATE SIGNED <u>11-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 13, 1955</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11/12/55</u>		<u>Julia A Rowan</u>		<u>William H. Kight, Cumberland, Md.</u>			

1955 CERTIFICATE OF DEATH

166

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF MARRIAGE OFFICIAL

22. SIGNATURE OF COURT OFFICIAL

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF PROSECUTOR

26. SIGNATURE OF DEFENSE ATTORNEY

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF PROSECUTOR

30. SIGNATURE OF DEFENSE ATTORNEY

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF PROSECUTOR

34. SIGNATURE OF DEFENSE ATTORNEY

35. SIGNATURE OF JURY

36. SIGNATURE OF JUDGE

37. SIGNATURE OF PROSECUTOR

38. SIGNATURE OF DEFENSE ATTORNEY

39. SIGNATURE OF JURY

40. SIGNATURE OF JUDGE

41. SIGNATURE OF PROSECUTOR

42. SIGNATURE OF DEFENSE ATTORNEY

43. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

45. SIGNATURE OF PROSECUTOR

46. SIGNATURE OF DEFENSE ATTORNEY

47. SIGNATURE OF JURY

48. SIGNATURE OF JUDGE

49. SIGNATURE OF PROSECUTOR

50. SIGNATURE OF DEFENSE ATTORNEY

51. SIGNATURE OF JURY

52. SIGNATURE OF JUDGE

53. SIGNATURE OF PROSECUTOR

54. SIGNATURE OF DEFENSE ATTORNEY

55. SIGNATURE OF JURY

56. SIGNATURE OF JUDGE

57. SIGNATURE OF PROSECUTOR

58. SIGNATURE OF DEFENSE ATTORNEY

59. SIGNATURE OF JURY

60. SIGNATURE OF JUDGE

61. SIGNATURE OF PROSECUTOR

62. SIGNATURE OF DEFENSE ATTORNEY

63. SIGNATURE OF JURY

64. SIGNATURE OF JUDGE

BUREAU N. 8

NOV 16 1955

RECEIVED

11/16/55 John R. Rogers

2001-10-17

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10861

10858

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>OAKLAND</u>				TOWN <u>DEER PARK</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>76 GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>Everrett Burns DEBERRY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 11 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>NOVEMBER 11, 1955</u>		9. AGE last birthday yrs. <u>9</u>	IF UNDER 1 YEAR (Months) (Days) <u>33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OAKLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>EVERETT BURNS DEBERRY</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET VIRGINIA BECKMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>DEER PARK MARYLAND</u> <u>HARRIET VIRGINIA DEBERRY</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Heart Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Abruptio Placenta</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Premature Birth (8 mos.)</u> STATING UNDERLYING CAUSE LAST.						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/11/55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/11/55</u> , 19 <u>55</u> , to <u>11/11/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/11/55</u> , 19 <u>55</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas D. Lushy</u> M.D.				ADDRESS (Street, city, town, state) <u>Oakland, Md</u>		DATE SIGNED <u>11/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov-1 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEMETERY</u>		LOCATION (City, town, or county) (State) <u>DEER PARK, MD</u>	
24. REC'D BY REGISTRAR <u>11/11/55</u>		REGISTRAR'S SIGNATURE <u>John A. Rowan JR</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>		ADDRESS <u>OAKLAND, MD</u>	

10001

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

111

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH

7. OCCUPATION
8. CAUSE OF DEATH
9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF JURY

25. SIGNATURE OF COURT

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF JURY

31. SIGNATURE OF COURT

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF JURY

37. SIGNATURE OF COURT

BUREAU V. S.

NOV 16 1955

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10862

10859 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>OAKLAND</u>				TOWN <u>RURAL KITZMILLER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R. F. D.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>XAVIER</u> (Last) <u>DEWITT</u>				(Month) <u>NOVEMBER</u> (Day) <u>18</u> (Year) <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>9/27/69</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>HOYES, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>JOHN DEWITT</u>				14. MOTHER'S MAIDEN NAME <u>MATTINGLY, ANNA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>UNK.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS. JESSIE RECKNER</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
591X IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosis, acute</u>						2 wks.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 5</u> , 19 <u>55</u> , to <u>Nov 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 18</u> , 19 <u>55</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph Alvarez</u> M.D.				ADDRESS (Street, city, town, state) <u>1012 Third St. Oakland Md. Nov 18.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>OAKLAND MD.</u>		LOCATION (City, town, or county) (State) <u>OAKLAND MD.</u>	
24. REC'D BY REGISTRAR <u>11/20/55</u>		REGISTRAR'S SIGNATURE <u>Julia A. Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Baldwin</u>		ADDRESS <u>OAKLAND? MD.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10860
Item 21f - 11-20-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10863
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 167

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>OAKLAND</u> <u>RURAL</u>				TOWN <u>OAKLAND</u> <u>RURAL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>RUTH</u> <u>ARLETTA</u> <u>FIRE</u>				<u>NOV.</u> <u>12</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>OCT.-3-1927</u>	<u>28</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>				<u>RED CREEK W. VA.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>EDWARD PROSPT.</u>				<u>MARTHA CARR.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
		<u>235-40-6149</u>		<u>MRS. VA. JOHNSON THOMAS W. VA.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause		(a) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
<u>823X</u>		<u>Crushing Injury right chest wall with fracture lung.</u>			<u>2 hrs.</u>		
Antecedent cause(s)		(b) DUE TO			<u>2 hrs.</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		<u>Fracture left femur</u>			<u>2 hrs.</u>		
		(c) <u>Fracture 11th - Cerv. Vertebrae</u>			<u>2 hrs.</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
				<u>11</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>Collision Automobile</u> <u>Car struck abutment of bridge</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				M. D.			
<u>E. J. Baumgartner</u>				<u>11/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 14-1955</u>		<u>THOMAS CEMETERY</u>		<u>THOMAS W. VA.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>11/16/55</u>		<u>Elmer C. Shaffer</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

BUREAU V. S.

NOV 21 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10861 CERTIFICATE OF DEATH

Reg. Dist. No. 10865
166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL- DEER PARK		LENGTH OF STAY (in this place) 79 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL- DEER PARK			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 MILES EAST		STREET ADDRESS (If rural give location) 2 Miles East					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) ARTHUR		(Middle) OSBORN		(Last) H ARDESTY		NOV. 17, 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 10, 1876	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Farming-Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY A. HARDESTY				14. MOTHER'S MAIDEN NAME JULIA ANN TASKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, in or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. ALICE HARDESTY, Rt. 1, Deer Park Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Heart Failure						INTERVAL BETWEEN ONSET AND DEATH Four days	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive arteriosclerosis						months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cardiovascular disease						6 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION none				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6 Sept. 19 49, to 10/29, 19 55, that I last saw the deceased alive on 10/29, 19 55, and that death occurred at 9 A.M. from the causes and on the date stated above.							
SIGNATURE Thomas J. Lushy M.D.				ADDRESS (Street, city, town, state) Oakland Md			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial				DATE THEREOF Nov. 20, 1955		NAME OF CEMETERY OR CREMATORY Moon cemetery	
24. REC'D BY REGISTRAR 11/20/55				REGISTRAR'S SIGNATURE John A. Rowan		25. FUNERAL DIRECTOR'S SIGNATURE O. A. Sharpless	
DATE				ADDRESS Blaine, W. Va.			

1900 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

U.S.A.

CERTIFICATE NO.

DATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

BUREAU V. S.

NOV 28 1900

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NOV 20 1900

DATE

11/20/00

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10866

10862 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cornett</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Allegheny</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Oakland</i>		<i>8 weeks</i>		TOWN <i>Oakland Westernport</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Weeks Nursing Home</i>				STREET ADDRESS (If rural give location) <i>7th & Alder St</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Mineral</i>		(Middle) <i>Glendora</i>		(Last) <i>Hightman</i>		(Month) <i>Nov</i> (Day) <i>14</i> (Year) <i>1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Sept 16, 1872</i>	<i>83</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>		<i>Own home</i>		<i>Ft. Ashby, W. Va.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John T. Greenwade</i>				<i>Sarah Wheeler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>None</i>		<i>None</i>		<i>Edrie Pence, Westernport, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4221 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>Congestive heart failure</i>						<i>2 mos?</i>	
ANTECEDENT CAUSE(S) DUE TO (B)						<i>year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<i>Art. C. V. D.</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Senile</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<i>None</i>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9/16</i> , 19 <i>55</i> , to <i>11/14</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11/17</i> , 19 <i>55</i> , and that death occurred at <i>7:00</i> M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Thomas J. Gushy</i>				<i>Oakland Md</i>		<i>11-14-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11/16/55</i>		<i>Queen's Point</i>		<i>Kepler, W. Va.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>11/14/55</i>		<i>Julia A Rowan RR</i>		<i>E. S. Boal - Westernport, Md</i>			

10002
1002

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

DEATH CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

DEATH

DATE OF DEATH

BUREAU V. S.

NOV 28 1955

RECEIVED

11/28 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film G190 12-22-55 ans

10863

CERTIFICATE OF DEATH

19867

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Garrett MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Oakland LENGTH OF STAY (in this place) 53 days HOSPITAL OR INSTITUTION OR STREET ADDRESS Evans Nursing Home 59 Oak Street				2. USUAL RESIDENCE (HOME) OF DECEASED STATE West Virginia COUNTY Preston CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rowlesburg STREET ADDRESS (If rural give location) Main Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Maude Knotts Hunter				4. DATE OF DEATH (Month) (Day) (Year) November 28, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH November 7, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months 0 Days 21	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rowlesburg, West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James A. Knotts				14. MOTHER'S MAIDEN NAME Sarah C. Hollis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS John J. Hunter, Rowlesburg, W. Va.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Arteriosclerotic Cardiac Vascular Disease						10 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) Fracture Rt. Hip						4 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) Home		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Rowlesburg W.Va.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 55 M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Missed step and fell			
22. I hereby certify that I attended the deceased from 15 Oct., 1955 , to 28 Oct., 1955 , that I last saw the deceased alive on 28 Oct., 1955 , and that death occurred at 11:50 A.M. from the causes and on the date stated above.							
SIGNATURE Andrew E. Mance M.D. Oakland, Maryland.				DATE SIGNED 29 Nov 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF November 30, 1955		NAME OF CEMETERY OR CREMATORY Eglon Cemetery		LOCATION (City, town, or county) (State) Eglon, West Virginia.	
24. REC'D BY REGISTRAR DATE 11/30/55		REGISTRAR'S SIGNATURE Julia A. Power L.P.		25. FUNERAL DIRECTOR'S SIGNATURE P. K. Watson ADDRESS Terra Alta, W. Va.			

BUREAU V. S.

1955 5 EC

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10864 CERTIFICATE OF DEATH

Reg. Dist. No. 10868
166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>OAKLAND</u>				TOWN <u>OAKLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOREE</u> (Middle) <u>FREELAND</u> (Last) <u>McROBIE</u>				(Month) <u>NOV.</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>DEC-3-1903</u>	<u>51</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>RETIRED U.S. MARINE</u>					<u>DEER PARK MD</u>		<u>U.S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOSEPH McROBIE</u>				<u>CLARA FREELAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>YES</u>		<u>WAR II.</u>		<u>MRS. MARY McROBIE OAKLAND MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 March, 1954</u> , to <u>10 November, 1955</u> , that I last saw the deceased alive on <u>10 November, 1955</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>A. E. Nance</u>		<u>Oakland Md</u>		<u>18 Nov 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>NOV-18-1955</u>		<u>OAKLAND CEMETERY</u>		<u>OAKLAND MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11/17/55</u>		<u>Julia A. Rowan</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

166

CERTIFICATE OF DEATH

1. DEATH REPORTED BY (NAME OF REPORTER)

2. NAME OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SIGNATURE OF REPORTER

15. SIGNATURE OF DEATH REPORTER

16. SIGNATURE OF DEATH REPORTER

17. SIGNATURE OF DEATH REPORTER

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10865

CERTIFICATE OF DEATH

Reg. Dist. No.

10869 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Oakland</u>		<u>6 weeks</u>		TOWN <u>Cumberland</u>		<u>01-02-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuppett Nursing Home</u>				STREET ADDRESS (If rural give location) <u>517 Caroline St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u>		(Middle) <u>FRANCE</u>		(Last) <u>NUTTER</u>		(Month) (Day) (Year) <u>Nov. 11, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Feb. 22, 1980</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Brunswick, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joel Wolfe</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Robert Zimmerman, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Art. C. V. D.</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Acute Pharyngitis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4</u> , 19 <u>55</u> , to <u>11/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Thomas J. Lundy</u> M.D.				<u>Oakland, Md.</u>		<u>11/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Nov. 14, 1955</u>		<u>Davis Memorial Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11/13/55</u>		<u>Julia A. Rowan</u>		<u>William H. Kight, Cumberland, Md.</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-V55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10866

CERTIFICATE OF DEATH

10870

Reg. Dist. No. 10866

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>OAKLAND</u>				TOWN <u>OAKLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>THIRD STREET</u>			
3. NAME OF DECEASED (Type or Print) <u>RUTH MARGARET PHILLIPPI</u>				4. DATE OF DEATH (Month) <u>NOVEMBER</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 3, 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HONDEL,</u>				14. MOTHER'S MAIDEN NAME <u>FRILL, MAGGIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>MRS. DAVID MARPLE</u> <u>THIRD STREET, OAKLAND, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>777PNEUMONIA</u>						<u>3 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF BREAST & METASTASES</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>GENERALIZED</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSION</u>						<u>Yrs</u>	
19a. DATE OF OPERATION <u>1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA OF RT. BREAST</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-20</u> , 19 <u>53</u> , to <u>Oct 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 31st</u> , 19 <u>55</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Tenenbaum M.D.</u>				ADDRESS (Street, city, town, state) <u>OAKLAND, MD.</u>		DATE SIGNED <u>11-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Nov. 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery Addison, Somerset, Pa.</u>		LOCATION (City, town, or county) (State)			
24. REC'D BY REGISTRAR <u>11/3/1955</u>	REGISTRAR'S SIGNATURE <u>Julius A. Rowan R.R.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel A. Black, Conowingo, Pa.</u>		ADDRESS			

Department of
the Imperial
College School of
Engineering

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10867 CERTIFICATE OF DEATH

Reg. Dist. No. 10871
166

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>GARRETT</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>GARRETT</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL OAKLAND</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL OAKLAND</u>	TOWN <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u>		STREET ADDRESS <u>1</u>	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>GRACE</u> (Middle) <u>ELVIRA</u> (Last) <u>REAMS.</u>		(Month) <u>Nov.</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL-20-1898</u>
9. AGE last birthday <u>57</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>OAKLAND MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELMER CROSS</u>		14. MOTHER'S MAIDEN NAME <u>FAYNABELLE SINES.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>RT-1 BLISS REAMS OAKLAND MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>March 55?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma left breast</u>		18mos.?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>3-12-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma left breast</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1/55</u> , 19 <u>55</u> , to <u>9/8/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>55</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Thomas J. Smith</u>		DATE SIGNED <u>9/9/55</u>	
ADDRESS (Street, city, town, state) <u>Oakland Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov. 11-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>TAYLOR DINES CEMETERY</u>		LOCATION (City, town, or county) <u>NEAR OAKLAND MD.</u>	
24. REC'D BY REGISTRAR <u>Julia A Rowan LR</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Boldin</u>	
DATE <u>11/10/55</u>		ADDRESS <u>OAKLAND MD.</u>	

CERTIFICATE OF DEATH

Form 100-1 (Rev. 1-54)

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF OTHER

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10868 **CERTIFICATE OF DEATH**

10872

166

Reg. Dist. No. *Allegany*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>GARRETT</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>GARRETT</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>OAKLAND</i>				TOWN <i>OAKLAND</i>		<i>Cumberland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Evans Nursing Home</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>MATILDA</i> (First) <i>SWISHER</i> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov. 19 1955</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>FEB-12-1876</i>	9. AGE last birthday <i>79</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>CUMBERLAND MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>FRANK GOELLNER</i>				14. MOTHER'S MAIDEN NAME <i>ELIZABETH HENDLE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <i>Carcinoma of Cervix</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Mulnutrition</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 10 1955</i> , to <i>Nov 19 1955</i> , that I last saw the deceased alive on <i>Nov 10 1955</i> , and that death occurred at <i>11:05 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>E. J. Zimmerman</i> M.D.				DATE SIGNED <i>11/21/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>Nov-22-1955</i>		NAME OF CEMETERY OR CREMATORY <i>ROSE CEMETERY</i>		LOCATION (City, town, or county) (State) <i>CUMBERLAND MD.</i>	
24. REC'D BY REGISTRAR <i>Julius Rowan</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Emory Bolden</i>		ADDRESS <i>OAKLAND MD</i>	
DATE <i>11/21/55</i>							

CERTIFICATE OF DEATH

166
C. J. [unclear]
[unclear]

Carroll Nursing Home

RECEIVED
NOV 28 1955
BUREAU V. S.

11/21/55
[unclear]

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10873

10869 CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 2, Film G189, 11/25/55 fcy

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY Garrett MARYLAND				STATE MARYLAND COUNTY West Virginia			
CITY (If outside corporate limits, write RURAL and give nearest town) OR Oakland TOWN 3 mo.				CITY (If outside corporate limits, write RURAL and give nearest town) OR Ridgeley, West Virginia TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Weeks Nursing Home				STREET ADDRESS (If rural give location) 18 Johns Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Iskel F. Welch				4. DATE OF DEATH (Month) (Day) (Year) Nov. 5, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 17, 1901	9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter's helper			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waynesboro, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Everett Welch				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-2500		17. INFORMANT & ADDRESS Joseph Welch, Cumberland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 151X IMMEDIATE CAUSE (A) Carcinoma of Stomach						?	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 2/15/55		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/28/55 , 19... to 11/5/55 , 19..., that I last saw the deceased alive on 11/1/55 , 19..., and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
SIGNATURE Thomas J. Kish M.D.				ADDRESS (Street, city, town, state) Oakland Md		DATE SIGNED 11-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/8/1955		NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		LOCATION (City, town, or county) (State) near Cumberland Md.	
24. REG'D BY REGISTRAR 11/7/55		REGISTRAR'S SIGNATURE Julia A. Rowan		25. FUNERAL DIRECTOR'S SIGNATURE William Kight		ADDRESS Cumberland, Md.	

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BUREAU V. 4

NOV 16 1951

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NOV 16 1953

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10879

CERTIFICATE OF DEATH

10874

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Grantsville</u>		TOWN <u>Grantsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Alpheus Jerome Whitacre</u>				<u>Nov. 8, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 30, 1869</u>	<u>86</u> yrs.	Months <u>1</u>	Days <u>8</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Minister</u>				<u>Okonoko, W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jesse W. Whitacre</u>				<u>Mary C. Sirbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Jesse W. Whitacre Grantsville, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						<u>17 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>20 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u>, to <u>Nov 8, 1955</u>, that I last saw the deceased alive on <u>Nov 7, 1955</u>, and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. Paige Strong</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Penn.</u>		DATE SIGNED <u>11/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-11-55</u>		<u>Abe Cemetery</u>		<u>Wiley Ford, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11-11-55</u>		<u>Ethel Broadwater</u>		<u>Rogers Funeral Home</u>		<u>Keyser, W. Va.</u>	

10075

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

BUREAU V. S.

NOV 24 1955

RECEIVED

10075

MARYLAND STATE DEPARTMENT OF HEALTH
10871 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10875

166

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Barrett</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> TOWN <u>Mt. Lake Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Barrett</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> TOWN <u>Mt. Lake Park</u> STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSEBY</u> (First) <u>CLIFFORD</u> (Middle) <u>WILSON</u> (Last) SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		4. DATE OF DEATH <u>Nov 20</u> 19 <u>55</u> 8. DATE OF BIRTH <u>11 Feb 86</u> 9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Lake Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Molly Craig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>209-01-5145</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lucy Wilson, Mt. Lake Park, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Probable Coronary Occlusion</u> Antecedent cause(s) (b) <u>(Previous episode 1 yr. ago)</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>2 hours</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE Thomas J. Lushy M.D. (Degree or title) ADDRESS Oakland, Md. DATE SIGNED 11-20-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>11/23/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>
DATE REC'D BY LOCAL REGISTRY <u>11/22/1955</u>	REGISTRAR'S SIGNATURE <u>Julian Roman</u>	24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>	ADDRESS <u>Oakland, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JEC 6 1955

BUREAU V. S.